From Start to Finish: Building and Sustaining Person-Centered Planning

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Overview of Day

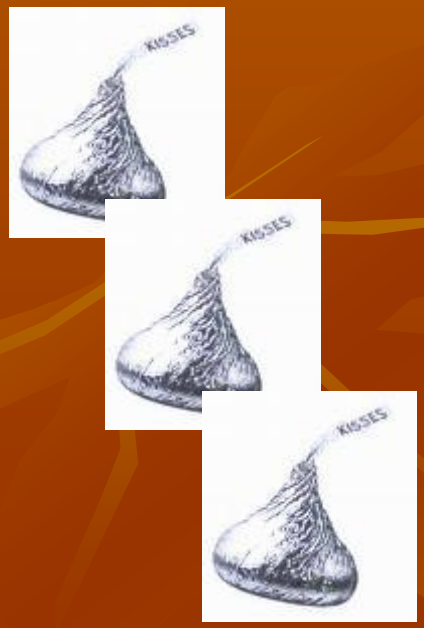
- Opening exercise
- A quick review
- **EXERCISE:** Applying What We Know to Move Forward
- BREAK
- Breaking Down the PCP Process: 8 Key Steps
  - Orientation and Intake
  - Pre-Planning: Education and Preparation
  - Strengths-based Assessment
  - Enhancing Forms and Templates - **EXERCISE**
- 8 Key Steps Continued
  - The Planning Meeting
  - Co-creating the Plan - **EXERCISE**
  - Evaluating Progress
  - Maintaining the Record
- LUNCH
- Putting It All Together: **EXERCISE**
- Thorny Issues Revisited (Including Risk v. Safety EXERCISE)
- Concluding Discussion and Group Brainstorming

Where to Start?

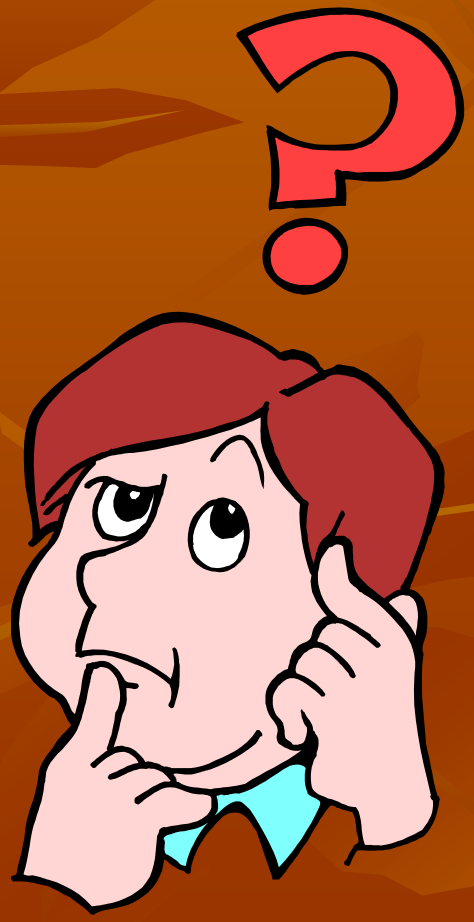
- To build a healthy PCP team around an individual requires that you first build and nurture a healthy ACT team among yourselves!
- One way to do this… *treat yourselves – and each other - as you strive to treat your clients.* The strengths-based approach applies to your team as a whole and each of its members!
- *A group becomes a team when each member is sure enough of himself and his contributions to praise the skill of the others. (Norman S Hidle)*

Opening Exercise: Hugs of Appreciation (the "Hershey" kind not the touchy-feely sort!)

- Three "hugs" total
  - One hug to recognize something positive you bring to the team; a skill, an attitude, a behavior, an accomplishment, personal OR professional, etc.
  - Two hugs to recognize your appreciation of others, i.e., how someone has made a difference in your life/work, how someone reached out to you, what you have learned from someone, etc.
  - Be specific, use examples, e.g., *"When I first started, it meant so much to me that you…"*
  - Must be given to two separate individuals. SPREAD THE LOVE FOLKS ☺



Process Questions: Hugs of Appreciation



- *How did it feel to receive a Hug?*
- *How did it feel to give a Hug?*
- *Were there any surprises?*
- *How do you already, or can you in the future, build in this kind of positive affirmation to your team on an ongoing basis?*
- *YOU NEED THIS TO SUSTAIN THE HARD WORK INVOLED IN PCP!*

A Quick Review

- The importance of moving beyond “us” and “them” thinking…
- How is PCP different from traditional planning and service models?
- What are representative “key practices”?

Recovery for “them”…

- ✓Compliance with treatment
- ✓Decreased symptoms
- ✓Stability
- ✓Better judgment
- ✓Increased Insight…Accepts illness
- ✓Follows team’s recommendations
- ✓Decreased hospitalization
- ✓Abstinent
- ✓Motivated
- ✓Increased functioning
- ✓Residential Stability
- ✓Use services regularly/engagement
- ✓Cognitive functioning
- ✓Realistic expectations
- ✓Attends the job program/clubhouse, etc.

Wellness for “us”

- ✓A home to call my own
- ✓Life worth living
- ✓A spiritual connection to God/others/self
- ✓A real job, financial independence
- ✓Being a good mom…dad…daugther
- ✓Friends
- ✓Fun
- ✓Nature
- ✓Music
- ✓Pets
- ✓Love…intimacy…sex
- ✓Having hope for the future
- ✓Joy
- ✓Giving back…being needed
- ✓Learning

A New Direction in Behavioral Health	
Traditional Approaches	**Person-Directed**
Self-determination comes *after* individuals have successfully used treatment and achieved clinical stability	Self-determination and community inclusion are fundamental human rights of all people
Compliance is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have full access to the same information – often referred to as “transparency.”
Disabilities and deficits drive treatment; Focus is on illness	Abilities/choices define supports; Wellness/health focus
Low expectations	High expectations
Clinical stability or managing illness	Quality of life and promotion of recovery
Linear progress and movement through an established continuum of services	Person’s chooses from a flexible array of supports and/or creates new support options with team
Professional services only	Diverse supports (professional services, non-traditional services, and natural supports)
Facility-based settings and professional supporters	Integrated settings and natural supporters are also valued
Avoidance of risk; protection of person and community	Responsible risk-taking and growth

Key Practices in Implementation

- Adhere to person-centered principles in the process
  - Person is a partner in all planning activities/meetings
  - Person has reasonable control over logistics including invitees and location
  - Person ALWAYS offered a copy
  - Preparation and leveling the playing field

Key Practices in Implementation

- Conduct a strengths-based inquiry to inform the plan
  - Conducted as a collaborative process – not an interrogation
  - Solicitation of strengths from diverse areas, e.g., familial roles, cultural traditions,
  - Creativity is key – NOT, *What are your vocational aspirations?* BUT, *Think back when you were a kid, what did you want to be when you grew up?*
  - USE the information!

Key Practices in Implementation

- Recognize the range of contributors to the planning process
  - e.g., Plans reflect (in attendees and interventions) a wide range of both professional supports and alternative strategies
- Value community inclusion
  - e.g., Plans respect the fact that services and professionals should not remain central to a persons' life over time

Key Practices in Implementation

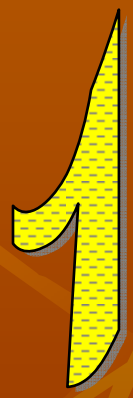
- Demonstrate a commitment to both outcomes and process
  - e.g., Expectations are high for successful outcomes in a broad range of QOL dimensions; Process tools (quality indicators, checklists) are flexibly applied to promote quality care.
- Understand and support human rights such as self-determination
  - e.g., People are encouraged to write their own crisis and contingency plans/advance directives

Applying What We Know to Move Forward

- Where we are:
  - *Patient is a 43 year old, African American schizophrenic female with a long history of multiple psychiatric hospitalizations dating back to the age of 21. Throughout her twenties, patient also abused alcohol but refused to acknowledge her addiction or engage in services. After several treatment failures and after developing medical complications secondary to her ETOH use, the patient got connected to 12-step and this has enabled her to be abstinent for nearly a decade.*

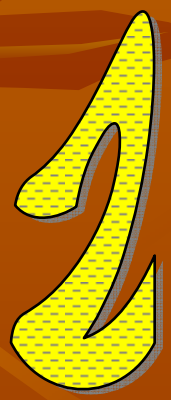
Applying What We Know to Move Forward

- Where we need to go:
  - *Sandra is a 43-year old African American woman with a diagnosis of schizophrenia. Throughout her twenties, she also had an addiction to alcohol (up to 1.5 liters of vodka daily) but she did not recognize it as a problem or see the benefits of a sober lifestyle. Her ambivalence initially made it difficult for her to benefit from different treatment programs that were offered to her. However, after developing medical problems related to her alcohol use, Sandra pursued involvement in 12-step and started actively working the program. She will celebrate 10 years of sobriety next month.*



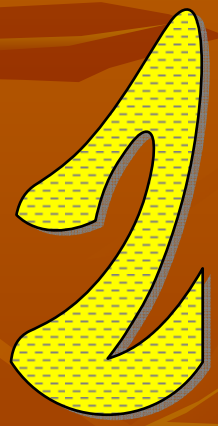
Applying What We Know to Move Forward

- Where we are:
  - *Patient continues to suffer from chronic psychiatric symptoms including auditory hallucinations, persecutory delusions, and paranoia. Due to the severity of these symptoms, she is low-functioning in ADL areas, and has, in the past, required residential, case management, and med monitoring services to address these weaknesses.*

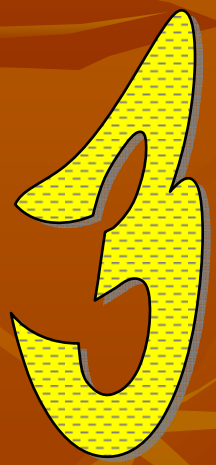


Applying What We Know to Move Forward

- Where we need to go:
  - *Sandra has continued to experience psychiatric symptoms such as auditory hallucinations (hearing voices talking to her through the washing machine), persecutory delusions (a persistent belief that a previous landlord maliciously marred her credit report), and paranoia (a fear that the public water supply is poisoned). In the past, these symptoms have occurred on a daily basis and have been highly distressing to her. Their severity has made it difficult at times for her to concentrate and to manage household tasks like paying her bills and keeping her apartment clean. At these times, Sandra has effectively used case management and residential supports to help her manage her symptoms and reduce their impact on her daily routine.*



Applying What We Know to Move Forward



- Where we are:
  - *For the last 18 months, patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last 2 visits and the team suspects she is off her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.*

Applying What We Know to Move Forward

- Where we need to go:
  - *In the last 18 months, Sandra has worked with her psychiatrist to find a medication regimen that is highly effective for her and she has been an active participant in activities at the clinic and the social club. Sandra and her supporters all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. However, people have become concerned lately as she has been missed at several activities in recent weeks, including a bloodwork appointment at today's clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.*

Applying What We Know to Move Forward

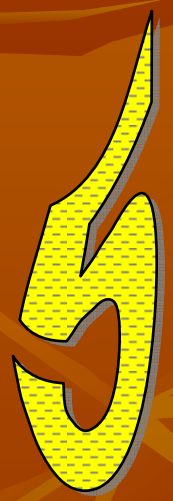
- Where we are:
  - *Patient returned to work against the advice of her treatment team and she reports that the is having problems with her new boss. Patient believes her boss "has it in for her" because he won't let her leave early to attend her appointments at the clinic. Patient appears to be getting increasingly symptomatic and paranoid.*

Applying What We Know to Move Forward

- Where we need to go:
  - *Sandra let us know that she took additional hours in her job as a cashier but she is now having problems with her boss. He is aware she is in treatment at the clinic, and he won't let her leave 15 minutes early to come to her appointments. She feels this is unfair and this is making her job stressful. Despite the issue with her boss, she has made friends at the job and wants to keep it. This is a source of stress for her but she does not report any marked increase in symptoms of psychosis.*

Applying What We Know to Move Forward

- Where we are:
  - *Patient has taken on activities (e.g., employment) that are interfering with her ability to attend treatment and this has precipitated clinical decompensation. Team will discuss and advise patient to cease employment activities and to re-engage in services until stable.*



Applying What We Know to Move Forward

- Where we need to go:
  - *Sandra is having difficulty working the recovery plan that she developed with her Recovery Team and she has asked for support to problem-solve ways to manage the situation with her boss. Plan to meet with Sandra to discuss and develop an action plan that allows her to maintain her employment while also having time to attend various groups/activities that she feels are helpful to her in managing her recovery and wellness.*

Think about it…

- Ask yourselves about the language, tone, and messages in the "where we are?":
  - Hopeful vs. gloom and doom?
  - Active agent vs. passive recipient?
  - Past vs. future oriented?

- And ask yourselves:
  - What if you, or a loved one, were described in this manner?
  - Would you feel hopeful about your future or in despair with the present?
  - Would you feel like a partner with your provider or like an outsider in the process?
  - As a provider, what types of interventions stem from the deficit-oriented, "where we are" place?

Before we break:
Tell me 10 things you have learned (or been reminded of) so far this morning?
Fast as you can – GO!

Breaking Down the PCP Process

1. Orientation and Intake to the Team

2. Pre-Planning: Education and Preparation

3. Strengths-based Assessment to Inform the Plan

4. Enhancing Forms/Templates

5. The Planning Meeting

6. Co-creating the Plan

7. Evaluating Progress

8. Maintaining the Record

6. Co-Creating the Plan:

a) Goals

b) Objectives

c) Interventions

Orientation and Intake to the Team

- Transparency/collaboration in LOC decision-making
- What does your intake process look like currently?
  - What type of info/messages are they given about their diagnosis ?
  - Are people given orientation materials to the agency/team and what it provides? If so, what type of materials?
  - Who is involved? Wherever possible, have Peer Specialists co-facilitate the initial interview to assist with engagement, answering questions, offering hope

Orientation & Intake to the Team

- *Building Your Recovery Toolbox: What You Need to Know about ACT and its Supports.*
  - What is ACT and What Can You Expect?
  - Your Rights and Responsibilities as Person Receiving ACT Services
  - Person-Centered Planning: Our Role, Your Role, Your Team's Role
  - Recovery Narratives with Pictures
  - User-friendly material describing wide-range of services, e.g., Spotlight on Peer Support, Supported Employment, Psychosocial Programming, WRAP
  - Clarify "dicey" areas: Medication Management, Money Management, Advance Directives, Clinician Transfer, etc.
  - A Community Resource Guide
  - *If only I knew then, what I know now…* Involve current ACT clients or graduates help you compile a list and use this to do a Q&A form

Pre-Planning: Education and Preparation

- A supporter (clinical/rehab/peer) should provide the person (and natural supporters as appropriate) with an orientation to PCP so that they are prepared to actively participate in the process. Ask how this is similar to/different from their past experiences in planning. Also encourage/assist the person to:
  - Learn about the basic function of treatment plans and roles of key players
  - Review their plan to reflect on progress; decide if changes in goals/ supports are desired.
  - Share this plan with a trusted other to receive feedback and ideas
  - Decide possible invitees? Who can help you to get what you want? Who do you trust?

Pre-Planning: Education and Preparation

- Also encourage/assist the person to:
  - Ask invitees what times would make it more convenient for them to be involved
  - Speak up if there is anyone they feel should not attend their planning meeting
  - Identify the most important priority areas in need of attention
  - Make notes of things they want to communicate in the meeting
  - Think about how they will communicate during the meeting if they are happy/unhappy about what is being said or talked about
  - Take a comprehensive inventory of strengths/resources to enhance plan

Strengths-based Assessment to Inform the Plan

- ***Personal Strengths:*** e.g., What are you most proud of in your life? What is one thing you would not change about yourself?
- ***Interests and Activities:*** e.g., If you could plan the "perfect day," what would it look like?
- ***Living Environment:*** e.g., What are the most important things to you when deciding where to live?
- ***Employment:*** *e.g.,* What would be your ideal job?
- ***Learning:*** e.g., What kinds of things have you liked learning about in the past?
- ***Trauma:*** e.g. In previous relationships, have you ever been treated inappropriately or in ways that were harmful to you (e.g., poor boundaries, sexual inappropriateness, physical abuse, etc.)?
- ***Safety and Legal Issues:*** e.g., Do you have any legal issues that are causing you problems?

Strengths-based Assessment to Inform the Plan

- ***Financial:*** *e.g.,* Would you like to be more independent with managing your finances? If so, how do you think you could do that?
- ***Lifestyle and Health:*** *e.g.,* Do you have any concerns about your overall health? What are those concerns? Tell me a bit about your mental health: What does a good day look like? A bad day?
- ***Choice-Making:*** *e.g.,* What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?
- ***Transportation:*** ***e.g.,*** How do you currently get around from place to place? What would help?
- ***Faith and Spirituality:*** ***e.g.,*** What type of spiritual or faith activities do you participate in?
- ***Relationships and Important People***: e.g., Who is the person in your life that believes in you? In what ways does this person convey this belief in you?
- ***Hopes and Dreams:*** **e.g.,** Tell me a bit about your hopes or dreams for the future?

Strengths-based Assessment to Inform the Plan

- **Culturally Appropriate Assessment and Formulation as per DSM-IV (see Appendix I):**
  - Cultural Identity: cultural reference groups; language (s): cultural factors in development; involvement with culture of origin
  - Cultural explanations of illness: idioms of distress; meaning of symptoms in relation to cultural norms; perceived causes; help-seeking behavior
  - Cultural factors related to psychosocial environment and levels of functioning: social stressors; social supports; level of functioning/disability
  - Cultural elements of the clinician-patient relationship: clinician's ethnocultural background; language; knowledge of patient's culture

Strengths-based Assessment to Inform the Plan

- **Sample questions to consider:**
  - How do you identify culturally/racially/ethnically? What is your culture? Where are you from?
  - How long have you been living in WA?
  - Who do you include as family? Who do you trust?
  - Does most of your family live in WA? If not, where are they?
  - What does your culture/family say about mental health problems? How does your family respond to you?
  - What do you call your problem? What caused it?
  - What is it like for you as a Black woman/Latino woman/Korean man living with mental health challenges?
  - Are you a member of a faith community now? If so, would you like the Rabbi, Priest, Pastor, Imam, etc. involved in your team?
  - Are you now going, or have you ever gone, to an Indigenous Healer for help with your problem? Would you like that person involved as part of your recovery support network?
  - What were the messages about your culture that you received while growing up? About the cultures of others?
  - Have you ever experienced racism, police brutality, discrimination and/or other forms of oppression?

Enhancing Forms/Templates

- The plan is only as good as the person (correction, TEAM!) filling it out, but the reverse holds true as well!

- Form design and administrative procedures can significantly impact the nature of the service planning experience and the result thereof. Forms must be constructed very thoughtfully in order to prompt provider behavior that is consistent with PCP.

- If you have the opportunity to modify, or create anew, your documentation templates/forms – make the most of it and THINK PCP!

- *I feel like I keep trying to force a square peg into a round hole.*

- CT Case Manager on trying to do recovery-oriented work with traditional treatment plan.

One Sample:
The Automated Recovery Plan (ARP)

Completing the ARP worksheet changes the nature of the dialogue

- The worksheet process:
  - Assumes an open, transparent conversation
  - Builds in a process to openly discuss differences
  - Requires shared decision making

Enhancing Forms/Templates

- **What do you look for in modifying/designing your documentation/forms? Review sample ARP and consider…**
  - Placement/attention given to strengths?
  - Role and placement of diagnosis?
  - Order and types of goal areas?
  - Ensuring consumer input?
  - Signatures and participation section?
  - Ways to prioritize and focus?
  - Language, jargon?
  - Who are the "responsible parties" in action steps?
  - Ways questions are asked/info is solicited?
  - Maximizing other recovery tools, e.g., WRAP?

The Planning *Meeting (s?)* – Consumer Role

- Has the leadership role in developing the plan
- Has ownership of the plan
- May or may not select the facilitator for the planning process
- Is responsible for full participation in the process
- Thinks about and communicates his/her hopes, dreams, desires, needs, likes, dislikes, etc. as clearly as possible using whatever means appropriate to their abilities
- Expects the facilitator, clinical service providers, family members, and other natural supporters to work with him/her not for him/her
- Builds relationships with planning team
- Is willing to be creative and take responsibility and risks to achieve his/her stated goals
- Stays committed to the process

The Planning *Meeting (s?)* – Family or Other Natural Supporter

- Believes in and values the person-directed planning process
- Listens to, understands, values, and respects the individual in recovery
- Is honest and open in communicating his/her perspective
- Treats all members of the team with respect
- Assists the focus person to identify his/her strengths and needs, and to formulate his/her wishes, hopes, dreams, concerns, etc.
- Shares knowledge and perspective re: what has worked/not worked for the individual in the past
- Uses "person-first" language
- Follows through on agreed-upon tasks
- Helps to identify and/or pursue resources available to the individual from the team or broader community
- Sees upsets and disappointments as opportunities to learns, grow, and try new strategies for goal attainment
- Believes in the individual's ability to have a positive impact on others and suggests ways in which the individual can do so
- Stays committed to the process
- Community members also pledge to facilitate the person's pathway to community activities of his/her choice by promoting welcoming and accommodating environments that encourage inclusion.

The Planning *Meeting(s?)*– Facilitator Role

- The Facilitator (may, or may not, be primary clinician) embraces all responsibilities common to other attendees in addition to the following:
  - Is an advocate for the focus person
  - Is able to work with meeting participants in an informal way
  - Provides unconditional support to the individual throughout the process
  - Adjusts the level of facilitation and support as the based on the individual's preference and current abilities
  - Encourages the focus person to be as active and empowered as is possible and preferred
  - Uses "person centered" and "people first" language and encourages others to do the same
  - Helps clarify and communicate the individual's ideas to members of the team
  - Encourages the individual to be creative in his/her plan and to take action, responsibility, and responsible risks

The Planning *Meeting(s?)* – Facilitator Role

- The Facilitator (may, or may not, be primary clinician) embraces all responsibilities common to other attendees in addition to the following:
  - Guides the planning process, keeping everyone and everything focused on the individual's wants, needs, desires, dreams, and hopes for his/her life
  - Ensures that all perspectives are heard and given due respect
  - Uses various tools to help individuals to share their story of recovery
  - Uses consensus building skills
  - Is able to use various means of conflict resolution to manage disputes and/or breakdowns in the planning process
  - Maintains a record of the planning
  - Helps planning team to see and/or use upsets and disappointments as opportunities to be creative and try new strategies for goal attainment
  - Reviews and evaluates the process in partnership with the focus person and others as appropriate

The Planning Meeting – How Tos

- Prior to the meeting – gather informing documents such as WRAP plans, Advance Directives, and SBAs. Discuss with consumer.
- Collect info from members who could not be present at meeting
- Review "Tickle List" to prompt key PCP behaviors
- Consider meeting outside the Mental Health center; in a more natural & neutral location agreed upon with the consumer
- Have the consumer lead introductions and speak first
- Set a tone by reminding everyone to be an active participant and to speak up – refer back to orientation they should have received prior to the planning meeting
- Where available, have summaries of the strengths-based assessment available and distribute/review (with consumer's permission) at outset of the meeting

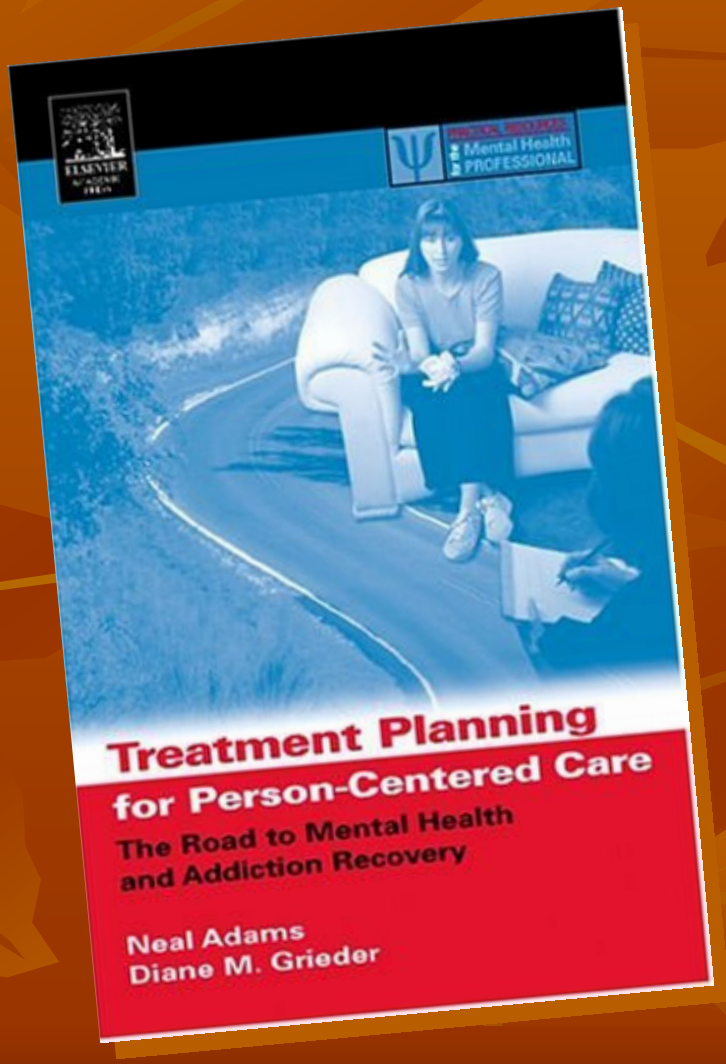
The Planning Meeting – How Tos

- Explore consumer satisfaction across a broad range of areas, even if they say "not currently interested,"
- Do not speak about the person or allow others to do so. Redirect back to the individual *"Well, what do you think, Kim?"*
- With the consumer's permission, share copies of the plan (or a summary of the meeting) with natural supporters to show value of their role/contributions
- Review topic areas, ask consumer what they wish to prioritize
- Develop goals and objectives from this conversation
- If a peer provider (or other) is attending, be a "Guide on the Side"
- Facilitator should re-direct/educate attendees who subvert the PCP process, e.g., "Its not good for him…can't you force him to stay at the group home where he belongs?"
- OTHER IDEAS – This is not a cookbook…

The Planning Meeting – How Tos

- Look for opportunities to maximize consumer or natural supporter actions prior to recommending professional services
- Invite consumer to draft the plan with you in next session; or draft and then review with consumer, “This is what it seemed we agreed on – Did I get it right?”
- Offer a copy automatically to the consumer to demonstrate partnership and to enhance ownership of the plan and action steps
- Solicit consumer’s feedback for hoe the meeting went and what could be improved, using established tools (e.g., PDP Checklist) or conversation

A Terrific Resource



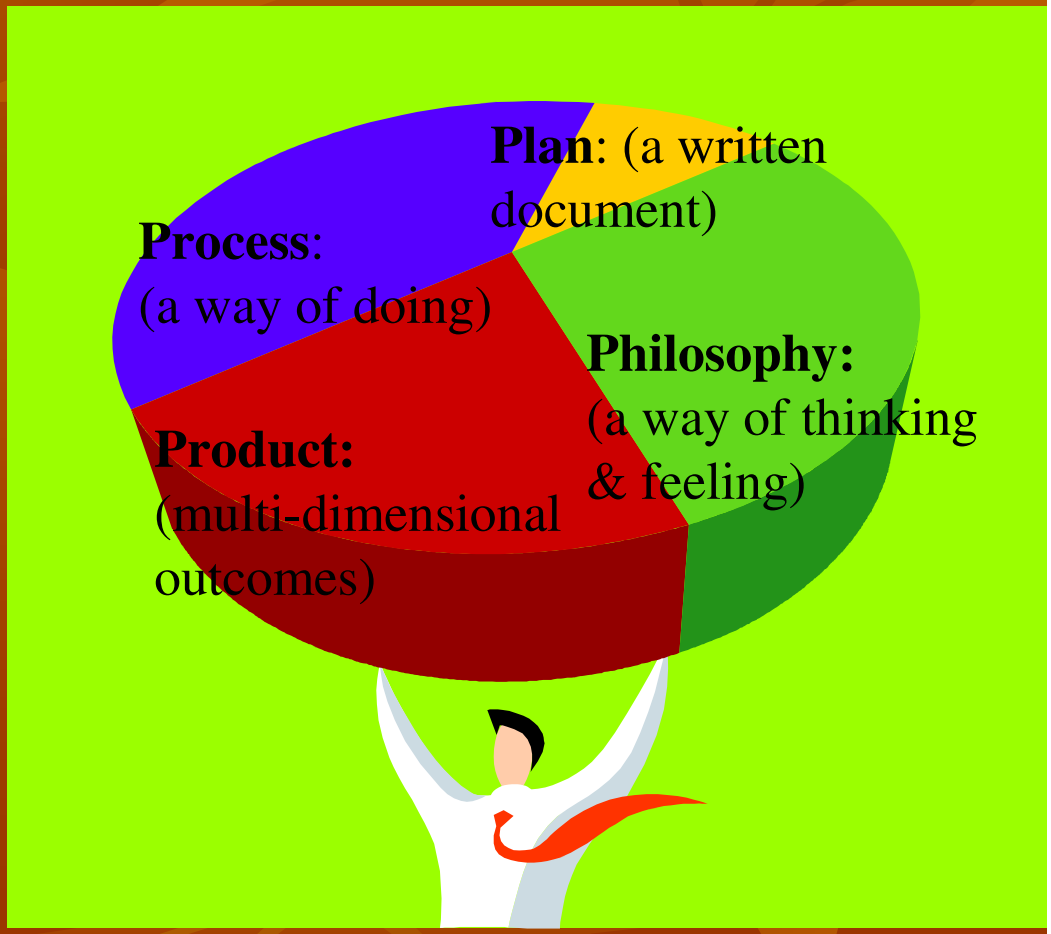
Before we move on to practice…

- The paper record, while a valuable tool for setting a course and reflecting on progress, is only one piece of the puzzle.

- Equally important, if not more important, is the PROCESS behind the development of the record. Don't lose the person by being overly focused on the paper plan!

- Its really all about the 5th – and most important "P" – the PERSON!

Remember, the "4 Ps"



Co-Creating the Plan: Goals

- Long term, global, and broadly stated
  - The broader the scope the less frequently it needs to change
- Person-centered
  - Ideally expressed in person's/ family's words
  - Easily understandable in preferred language
  - Appropriate to the person's culture
    - reflect values, life-styles, etc.
  - Consistent with desire for self-determination and self-sufficiency
    - may be influenced by culture and tradition

(*See Adams and Grieder, 2005)

Broaden the goals!
Mental Illness is NOT a Full-time Job

"Well, this is a very impressive resume', young man. we think you are going to make a fine patient."

Co-Creating the Plan: Goals

- **Life changes as a result of services**
  - Focus around which you build the alliance / collaboration
  - Readily identified by each person
- **Linked to discharge / transition criteria and needs**
  - Should describe an end point of helping relationship when goald are fulfilled
- **Essential features**
  - Attainable (but be careful about making judgments here)
    - written in positive terms (avoid the "client will not…)
    - built upon strengths, preferences and needs
    - embody hope
    - alternative to current circumstances

(*See Adams and Grieder, 2005)

Example Goal

- **Goal:**
  "To live in a peaceful home, where people get along"

- Strengths: Mary, who has a strong sense of herself, is a survivor of a long history of abusive relationships and unhealthy situations, including substance dependency. She is a creative individual, spiritual in nature, and connected to community resources such as her chosen religious organization and the 12 step community. She is motivated for services, attends groups and is doing well with her medications.

- Barriers: Unhealthy relationships, unresolved trauma issues, substance dependency, feelings of depression and anxiety, poor sense of body image and physical health concerns (diagnosed with Hepatitis C).

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Objectives

- Expected near-term changes to meet long-term goals
  - Divide larger goals into manageable tasks
    - risk of being too trivial or too grand
  - Provide time frames for assessing progress
  - Maximum of two or three per goal recommended
- Work to remove barriers
  - Must be active and positive (again, avoid the "client will not…")

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Objectives

- Build on strengths and resources
- Essential features
  - Behavioral
  - Achievable
  - Measurable
  - Time framed
  - Understandable for the person served

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Objectives

- Responsive to the person's individual disability, challenges and recovery
- Appropriate for the person's age, development and culture
- *"The individual / family will …"*
  - Changes in behavior / function / status
  - Described in action words
- *Services are not an objective*

(*See Adams and Grieder, 2005)

Example Objectives

- **Goal:**
  "To live in a peaceful home, where people get along"

- **Objective 1:**
  - Within 60 days Mary will identify at least two concrete barriers to her goal of "living in a peaceful home."

- **Objective 2:**
  - Within 90 days Mary will use at least three strategies to improve her physical well-being.

Co-Creating the Plan: Interventions

- *Actions* by person served, family, peers, staff and the entire system of care
  - may include role for family, support network, etc.
  - clarify who does what
- Specific to an objective
- Cultural efficacy must be considered
- Availability and accessibility of services may be impacted by cultural factors

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Interventions

- Well written and documented interventions should specify:
  - The **frequency** of intervention activity including how intense the intervention will be, i.e., 1/2 hour of social interaction one time per week
  - the **duration** of activity i.e. how long will the intervention last, 4 weeks, 6 months
  - **who** exactly is involved in the intervention, naming professional providers and, where applicable, the individual and natural supporters
  - the **purpose/intended impact** of the intervention as directed towards the objective
  - the **modality** being provided (oftentimes referred to as "the billable service"), e.g. group therapy, day support, or natural supports such as a family member providing transportation, involvement in a community group, etc.

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Interventions

- Interventions provided by the mental health system are usually billable. Interventions provided by family members, peers, or outside community supports are usually not billable. All interventions identified for a specific objective should be included on the service plan (whether they are billable or not).
- In addition, there should always be a role specified for the individual.

(*See Adams and Grieder, 2005)

Co-Creating the Plan: Interventions

- Utilize a wide range of both professional supports and alternative strategies to support the person's recovery:
  - Professional clinical interventions such as medications or psychotherapy
  - Self-help and peer-support,
  - Support with exercise and nutrition
  - Daily maintenance activities, e.g., WRAP toolbox
  - Spiritual practices and affiliations
  - Homeopathic and naturopathic remedies
  - Supported Community Living
  - Evidence-based practices

Co-Creating the Plan: Interventions

- Offer practical assistance
- Engage the person by developing a caring relationship "in vivo" rather than through treatment interventions per se
- Assist the person in
  - gaining autonomy and power
  - developing relationships with people in one's community
  - re-establishing, or establishing for the first time, socially valued roles that are of value to one's community, e.g., the role of worker/parishioner/neighbor/PTA member

Example Interventions

- **Objective 1:**
  Within 60 days Mary will identify at least two concrete barriers to her goal of "living in a peaceful home."

- **Interventions**:
  1) Mary and her therapist will work together for one hour a week in an individual session for 8 weeks regarding her living situation and develop her list of barriers to a peaceful home.
  2) If Mary and her therapist decide that trauma services are appropriate at this time, Mary's therapist and substance abuse counselor will together meet bi-weekly for 2 months with Mary for one hour to discuss risks, benefits and any safety precautions needed for doing simultaneous trauma and substance abuse counseling.
  3) Mary, her therapist and her substance abuse counselor will together meet with her AA sponsor and/or spiritual counselor for at least two one hour meetings within two weeks to build Mary's support team.
  4) Within 90 days, Mary will ask her friends to help her re-decorate her personal space so that it is more peaceful to her.

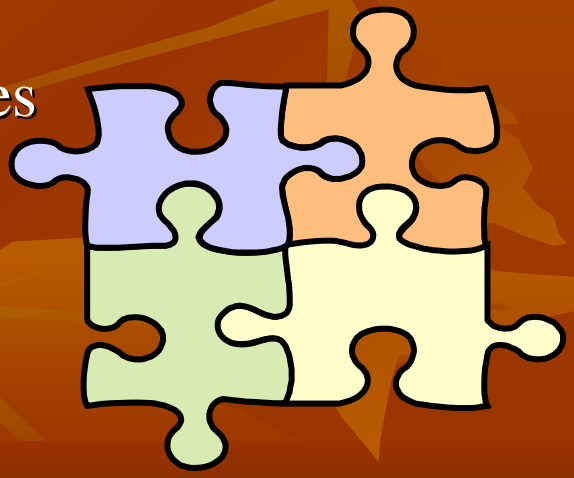
Example Interventions

- **Objective 2:**
  Within 90 days Mary will use at least three strategies to improve her physical well-being.

- **Interventions**:
  1) Care Coordinator will assist Mary as needed to facilitate Mary's access to the *Living with Hepatitis* clinic for medical and nutritional evaluation/consultation within 4 weeks.
  2) Rehab specialist will meet with Mary for 2 hours weekly for 4 weeks in her apartment to help her plan and prepare 2 nutritious meals a day.
  3) Mary's sister will support or assist Mary, as needed, in enrolling and attending YWCA exercise program to build physical stamina within 3 months.

Putting It All Together – Vignette Review

- **Procedures:**
  - Using the 3 vignettes provided, each group should take 20 minutes to write the following:
    - 1 goal statement: (global/positive/in persons words)
    - 2 associated objectives: (near-term positive changes /action-words/measurable/time-framed)
    - 2-3 interventions for each objective (frequency/duration/provider/purpose/modality)
  - Reconvene in large group. Each table shares sample goals/objectives/interventions.
  - Discussion re: how each meets established criteria. Re-work as necessary.



1. Chase

Chase is 22-year old female. Over the past four years she has received various mental health services, mainly for periods of confusion and hearing voices. The confusion and voices tend to become much worse when she is depressed or "stressed out". She moved from Texas to Connecticut one year ago hoping for a fresh start. Against her mother's advice, she enrolled in college classes and soon felt overwhelmed with the demands of her classes. Her voices became much worse and she was eventually hospitalized. Chase is referred to your team six-months after this hospitalization, and she seems to enjoy talking with you. After several meetings with Chase she mentions that she would like to begin to take college classes again. She had a good relationship with her instructors who were aware of, and supportive around, her mental health issues. However, her Mom is strongly against her returning to school at this time and she has urged her to take more time to "get things straight". She explains to you that she is still experiencing voices and recently had a several day period where she was too depressed to get out of bed. Her Mom is worried that Chase is rushing her return to school and that she will be hospitalized again, which would jeopardize her housing situation. It is clear to you that a big piece of Chase's vision of recovery includes returning to school. It is her dream to be a school teacher.

2. Chris

Chris has been receiving services at the mental health center for 5 years. He first started his treatment there after his first psychiatric hospitalization for depression with suicidal thoughts. He feels as if those days were a blur. He didn't feel like he had a handle on everything that was going on but figured that the professionals knew best and agreed to what they had planned out for him. Chris had been so depressed he had neglected all of his bills and was in jeopardy of eviction. His team decided to put him in a money management program where a counselor controlled his money, paying his bills and giving him a weekly allowance. He vaguely remembers agreeing to this set-up back when he first started treatment but now he feels like he would like to take control of this part of his life again and get himself back on track. Chris' family is concerned about him taking more control over his money (especially about him not paying rent) but his brother has offered to help him with budgeting and other financial matters.

3. Lakeesha

Sonia is a 23 year old Latino woman diagnosed with panic disorder who feels like she doesn't "have a real life – no friends, no fun, no future." She gets very anxious while taking the bus or when going to public places with crowds and this has severely hampered her quality of life. Before she got sick, Lakeesha was always very active and she was into movies, poetry, music, and her church choir. She stopped doing many of these things because of the panic attacks. Recently, her pastor at her church has been asking her to come back to choir, and her cousin has agreed to go with her, but Lakeesha still can't imagine going. She has learned lots of strategies from her therapist to reduce the panic but when she heads into church, the panic "just takes over." Her therapist has also suggested she attend the local social club that a lot of her friends attend. Lakeesha is open to this idea as a first step but prefers not to go somewhere that is just for people with mental illness. She really wants to sing in her church choir again.

Evaluating Progress

- The definition of quality must move away from organizational procedures and services toward the REAL impact of those services on the lives of the people supported.
- Valued outcomes have traditionally been limited to more narrow clinical indicators (e.g., inpatient hospitalizations, service utilization, clinical symptomatology, etc.)
- In a person-directed system, “progress” must be defined, and measured against, the individual’s valued goals and priorities.

Evaluating Progress

- EXAMPLE: The Council on Quality and Leadership in Supports for People with Disabilities has established a set of "Personal Outcome Measures" in consumer-directed behavioral health. Commonly valued indicators of progress include the following:
  - **identity** (satisfied with services, intimate relationships, worker roles, satisfied with housing and community role)
  - **autonomy** (choose their daily routine, opportunity for privacy; control over disclosure process and sharing of personal information)
  - **affiliation** (live/spend time in integrated environments, valued social roles, participate in community life, have friends, feel respected)
  - **attainment** (choose their services and attain goals)
  - **safeguards** (have supportive natural support networks)
  - **rights** (exercise rights;)
  - …as well as indicators of health and wellness

Maintaining the Record

- The person-directed recovery plan must be a "living" document that evolves over time to flex with the individual's needs, goals, and priorities
- The initial plan must be accompanied by ACTION & FOLLOW-UP, and this action and follow-up should be documented in the plan.

Maintaining the Record

- Reviews of the plan/record should not be triggered only by "crisis" events. This sends a message that care is merely about managing and surviving rather than growing and thriving.
- The team should re-convene around events of success/accomplishment as well to discuss next steps.
- PCP is about THRIVING not just SURVIVING!

LUNCH

Before we break:
Tell me 10 things you have learned (or been reminded of) so far this morning?
Fast as you can – GO!

Putting It All Together: PCP Role Play

- PART 1 (15 Minutes):
  - Carry out a PCP Role Play at your table. Don't worry, it is a group effort!
  - Complete a mock planning interview with Recovery Planning template provided applying what you have learned thus far.
  - Can use own case example or start with vignette provided or create as you go.
  - By table – One person adopts role of consumer; one the role of clinician, one is the recorder to fill in the interview as they go. Others are observers who should jump in and help/assist – offer ideas. If relevant to the course of the interview, the observer may take on the role of a natural supporter.
  - Consider switching roles mid-way to allow for greater participation.

Putting It All Together: PCP Role Play

- Part 2 (15 minutes):
  - Select 1 or 2 “Work On Now” areas
  - Complete a corresponding Action Page
  - Action page should identify at least one suggested goal/intervention/objective. For the “work on now area”

- Part 3 (15 minutes report back):
  - How did the interview feel? For the clinician/the consumer?
  - What did the observers notice?
  - What seems to work? What did not work? Where did you get stuck, reach an impasse with the consumer?
  - How did this role-play feel the same/different from typical planning meetings?

Sample Vignette if Desired

The individual you are supporting ("Sam") has carried out a number of pre-planning activities and has decided that his priority for his upcoming PCP meeting is to discuss, and make an action plan for, getting back to work. He has asked that you help him arrange a meeting and to invite his aunt and a supported employment specialist. After Sam leaves the office, his aunt returns your phone call and explains to you how excited she is to be invited to the meeting. She is very relieved that she will be able to work with you, his case manager, to convince Sam (and the employment specialist) what a terrible decision this is. She is well intentioned but worried. The last time Sam tried to go back to work (at a fast food restaurant), he got very symptomatic and ended up in the hospital. Sam hears voices that get very intrusive when he is under stress or over stimulated. Sam believes that he is ready and able to work at a place that is a "good fit." Get to know Sam through the Recovery Plan Interview and help him get back to work.

Thorny Issues – Revisited - $$

- ***Show me the money!!!! Who is going to pay for it!!***

- External pressures from
  - Regulatory
  - Accrediting
  - Payor
- Plan must meet multiple clinical as well as administrative functions

Serving Two Masters

Understanding

Person-centered

- Recovery
- Community integration
- Core gifts
- Partnering
- Supports self-direction

Regulation

- Medical necessity
- Diagnosis
- Documentation
- Compliance
- Billing codes

Outcomes and Goals

(*See Adams and Grieder, 2005)

Thorny Issues – Revisited - $$

- Medicaid has already been used in many creative ways by multiple State authorities and demonstration programs.
- Use federal dollars to fund whatever they can, and use general fund (and other, e.g., research, etc.) dollars to fund alternative services that are not reimbursable under Medicaid.
  - Many "person-centered" practices do NOT require new resources or funding mechanisms.
  - In building the plan it is sometimes both "recovery-savvy" and "fiscally-savvy" to leverage naturally occurring community resources.
  - Flexibly combine both professional (billable) services and natural supports.

Thorny Issues – Revisited - $$

- *I am so lonely. I just want a girlfriend. I used to go to the downtown jazz fests and meet lots of people. But I have been so exhausted lately, I can barely stay awake to go. The meds make me feel like a zombie. Even if I could, I am terrified. Its been 5 years since I had a girlfriend, I wouldn't know where to start…I can't take the bus anymore to get anywhere and I am afraid to go anywhere alone.*

  - Interventions:
    - Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.
    - Dr. X to meet with Greg two times monthly for next 6 months to review Sam' log for the purpose of adjusting meds for optimal functioning.
    - John Smith, Peer Specialist, will help Greg with travel training 1X weekly for 4 weeks to help him to become independent with city bus.
    - Greg's brother, Jim, will accompany Greg to a minimum of three community social outings over the next 2 months.
    - Therapist, Jane Roe, to provide CBT two times monthly to increase Greg's ability to cope with anxiety symptoms in social situations.

Guess Who?

- We define PCP as a process, directed by the individual, with assistance as needed… It is intended to identify the strengths, capacities, preferences, needs, and desired health and quality of life outcomes of the individual.
- The person-centered planning process must support and expand the consumer's informal community network.
- The PCP process enables the individual to identify personally defined goals in the most inclusive community settings and access a personalized mix of formal (paid) and informal (non-paid) services and supports that assist him/her to achieve those goals.
- Personally defined goals often include self-directing services and supports, having access to the community of choice, developing meaningful relationships, employment, access to and control over transportation, and control over one's home and daily life.

Guess Who?

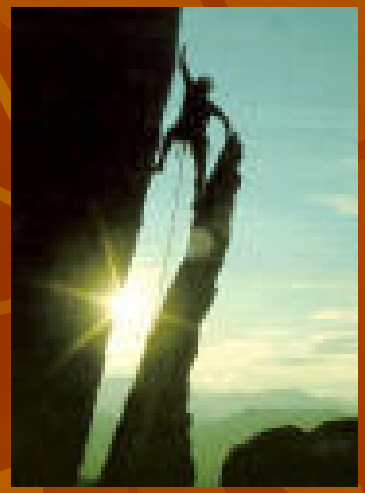
- PCP enlarges the traditional focus of care planning processes on formal service needs and group recreational activities (e.g., going to the mall) to include "supporting" the person's individual choices by developing and expanding friendships, and creating opportunities for the person to be a contributing community-member. Connecting the person in his/her community is a necessary, yet often overlooked part of a PCP.

- It is our expectation that, for persons with mental illnesses and substance-related disorders, the plan would include recovery goals as well as treatment goals.

- PCPs must document that the individual participated in the development of the plan, signed the plan, and received a copy of the plan.

Thorny Issues Revisited - Risk

- ***Show me the safeguards! Recovery exposes providers to increased risk and liability!***
- A recovery orientation in no way conflicts with risk assessment and encourages the appropriate use of this technology.
- Limit restrictive measures only to situations involving imminent risk to self or others ("safety" issues) as narrowly allowed under statutory law while encouraging "responsible risk taking"
- Advance directives, decision-making tools, etc.



RISK v. SAFETY

"Risk" is Inherent in Recovery…

"We've considered every potential risk except the risks of avoiding all risks."

NRC•PAD

National Resource Center on Psychiatric Advance Directives

MAIN MENU

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- Getting Started
- State by State Info
- FAQs
- Educational Webcasts
- Links
- Current Research
- In the News
- Legal Issues
- Discussion Forums
- Search
- Feedback

PAD STORIES

"....it was really crowded in the ER so I showed intake my psychiatric advance directive and told them that I needed to go somewhere quiet....so that I could calm down....The intake nurse sat with me in a quiet room until I calmed down." **Click for more...**

Home

Welcome to the National Resource Center on Psychiatric Advance Directives

Click state to view statute information.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit advance directives for healthcare, which can be used to direct at least some forms of psychiatric treatment. In the past decade, twenty-five states have adopted specific psychiatric advance directives statutes.

This site offers an introduction to psychiatric advance directives, state-by-state information about advance directives, instructions and forms, discussion forums, educational webcasts, current research, links to other websites, and more!

Do you want to learn how to write Psychiatric Advance Directives? **View webcast**

Washington State

- Advanced directives form and brochure available (in 8 languages!) for download from WA Department of Social and Health Services
- See: www1.dshs.wa.gov/mentalhealth/advdirectives.shtml

Recovery Oriented Risk Management*

Example: Client chooses not to take medications.

Client feels comfortable with this decision

Service Worker feels comfortable with this decision

YES

YES

NO

The Conflicted Zone

The Comfort Zone

DO: Strive to be supportive of the client's choice

DON'T: Be judgmental or parental by telling the client they made the "right choice."

National Institute of Mental Health, England (2003).
As adapted from Deegan (2001): Intentional Care: Employee Performance Standards for Client Choice See www.intentionalcare.org

Recovery Oriented Risk Management*

Example: Client makes a choice that appears to be self-defeating or that diminishes quality of life. Is informed of what might happen but still refuses.

Client feels comfortable with choice not to take meds.

Service Worker feels comfortable with this decision

YES

NO

The Conflicted Zone:

ASK: Does the client's choice pose an immediate and/or imminent threat to self or others?

YES → Develop risk management plan See Below

NO

Response Continuum

Neglect……Power/Control

DON'T ABANDON CLIENT	**DO**	**DON'T CONTROL**
Well, its his choice. There is nothing I can do about it. Its their life and its empowering to let them go off and do what they want. THIS IS NOT EMPOWERMENT THIS IS NEGLECT	Remain engaged and supportive Brainstorm other options Discuss Pros and Cons (MET) Educate about alternatives Give honest feedback	*I can't let him make this decision. Why can't he see medication is best. I know what is best. I have to find a way to get him to take his meds.* THIS IS EXERCISING POWER

Recovery Oriented Risk Management*

Example: Client has chosen not to take meds and has been informed of the risks. He is demonstrating behavior that is out of character and is interfering with his safety.

Client feels comfortable with choice not to take meds.

Service Worker feels comfortable with this decision

YES

NO

The Conflicted Zone:

ASK: Does the client's choice pose an immediate and/or imminent threat to self or others?

NO → Response Continuum See Above

YES

Risk Management

DO

- Consult with supervisor and/or team
- Remain engaged and openly communicate your concern and intent with the client
- INVITE the client to be involved in developing the RM plan
- Include specific criteria the client must demonstrate in order to have a less restrictive plan that restores freedom and personal choice

DON'T

- Develop a risk management plan on your own
- Assume that the client will always need a restrictive plan
- Rely on risk management: problem-solve with the client and team to prevent crises

Thorny Issues Revisited - EBP

- ***Show me the evidence! The EBP movement limit services that are to be funded to those that have been shown to be effective. Recovery is not evidence based!***

- Given the relative dearth of practices that are now recognized as "evidence-based," it is premature to limit systems of care to these few options. In the interim, it is critical to include in EBP initiatives both recovery-oriented and culturally-responsive services *while* collecting information on their utility and effectiveness.

From: Davidson, O'Connell, Tondora, Styron, & Kangas, 2006)

In the meantime…

- "Don't tell me that recovery is not evidence-based….I'm the evidence!"

- Woman with serious mental illness as quoted in Davidson, O'Connell, Tondora, Styron, & Kangas, 2006

What else?
Where are we stuck?…What are next steps?